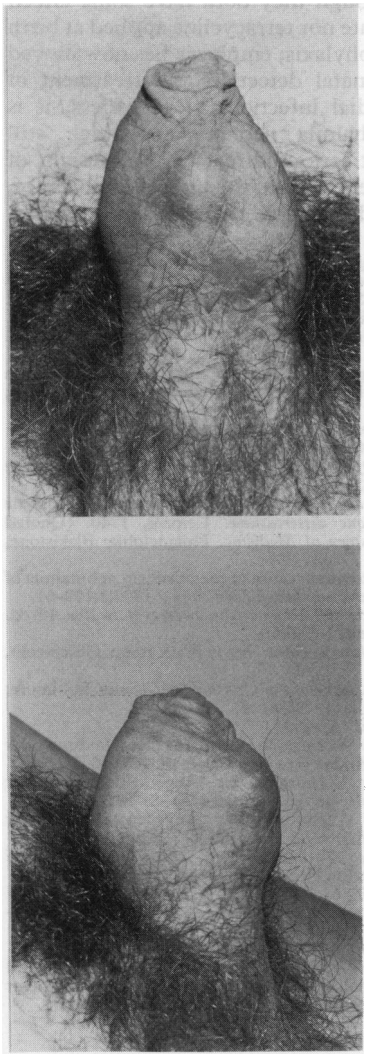
LETTERS TO THE EDITOR

Recurrent periurethral abscess

We report a case of recurrent periurethral abscess in a man, which is rarely seen nowadays.

A 23 year old single Caucasian heterosexual presented in our clinic in October 1989 with a one week history of a swelling on the ventral surface of the penis. He had no urethral discharge, dysuria, or a past history of STD nor had he had recent antibiotics. The patient had been seen in October 1987 with a discharging penile abscess at the same spot, which spontaneously resolved. Urine after three hours hold was clear. Routine tests were negative for pus cells, gonorrhoea, chlamydia and syphilis. Pus from the abscess grew *Staphylococcus albus*.



Examination on this occasion was unremarkable except for a multiloculated abscess (fig). Again routine STD tests were negative. The abscess was incised and drained under local anaesthesia. Scanty *S albus* was cultured from the pus. The patient's consort was untraceable. The abscess had nearly resolved when the patient was reviewed in two weeks following a 10 day course of oxytetracycline 500 mg tds. Final review at three months confirmed a pea-sized nodule at the site of the abscess. The patient's urinary flow was normal.

Delay in presentation or diagnosis of gonococcal/non-specific urethritis can result in a periurethral abscess.[1] Recurrent periurethral abscess is rare in the younger age group. The average age at presentation is 50 years. Congenital abnormalities of the median raphe, past history of urethritis or periurethral abscess are considered to be risk factors in the development of a recurrent periurethral abscess.[2,3] The commonest predisposing factor is urethral stricture, and presentation is a penile swelling, usually painless, which may resolve spontaneously.[3] Surgical repair may be required to salvage the urethra in cases of recurrent periurethral abscesses.

Our patient was young and his periurethral abscess preceded an earlier episode. Although he had no clinical or microbiological evidence of urethritis or urethral stricture, he was referred to the urologist to exclude any congenital abnormality which may be a possible cause in this patient.

S SIVAPALAN
R BASU ROY
Department of Genito-Urinary Medicine, Royal Victoria Hospital, Bournemouth BH7 6JF, UK.

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Non-gonococcal urethritis in men practising "safe" sex

It has been apparent for some time that orogenital contact is an effective way of transmitting genital pathogens,[1,2] although less has been written about the association between orogenital contact and the development of non-gonococcal urethritis (NGU). A recent study from Spain suggested that insertive oral sex was a risk factor in the development of NGU.[3] However, this conclusion was reached following statistical analysis of data derived from patients, the majority of whom had practised both anal intercourse in addition to oral sex. With the advent of the Acquired Immunodeficiency Syndrome, many individuals have modified their sexual behaviour to avoid potential infection. Most commonly, such modification involves the avoidance of unprotected, anal or vaginal intercourse. In our clinical practice we have found a large group of men, mostly homosexual, who are practising oral sex as their only unprotected form of sexual contact. We felt that this group provided a unique opportunity to explore an association between oral sex and the development of NGU.

Male patients were selected from the outpatient clinic, who had documented urethritis, and who gave a history of insertive oral sex as the only form of unprotected penetrative intercourse in the three months prior to presentation. Male patients who gave a history of anal or vaginal intercourse together with oral sex were still recruited if they had used condoms on every occasion for anal or vaginal intercourse (but not for oral sex) with no history of "condom accidents". The control group consisted of males with the same sexual history who were proven not to have urethritis following investigation. All patients had the following investigations performed;